UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

KALYDECO (ivacaftor)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992

CRITERIA

- Must be used for the treatment of cystic fibrosis. Please indicate the diagnosis code.
- Age ≥ 2 years
- Please include laboratory results verifying any of the following CFTR gene mutations:
  - G551D
  - G1244E
  - G1349D
  - G178R
  - G551S
  - R117H
  - S1251N
  - S1255P
  - S549N
  - S549R